APPENDIX L: SELECTED STATES WITH AN OMBUDSMAN OR EXTERNAL CONSUMER APPEALS PROCESS

House Bill 2785 directs the State Health Commissioner to examine whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans, and if so, whether the Department of Health or another entity should administer the process. The method for examining this question consisted of interviews with selected states which had an ombudsman or a consumer appeals process external to HMO internal complaint systems. The interviews were conducted during the months of March (subject to legislative changes) and August 1997.

Currently, all states require HMOs to have a grievance procedure in place. More than 30 detail specific procedures for the complaint system. The Center for Health Care Rights reports that 22 states explicitly provide HMO enrollees the right to take their grievances to the state, with seven of those requiring that the enrollee must first exhaust the HMO internal appeals process (Dallek, 1995). It should be noted that, while the right to complain may appear in state code, the degree to which states exercise their authority is unknown at this time. For example, California recently strengthened its procedures for the monitoring of enrollee grievances, and began to publicize a toll-free hotline, after receiving bad press from several highly publicized cases with adverse outcomes. Currently, no states provide adjudicative authority for enrollee/HMO disputes. New York limits binding arbitration by managed care plans with their enrollees. Alabama requires significantly detailed grievance procedures for HMOs operating in the state (Families USA, 1996). Mississippi recently enacted legislation providing the health department with authority for quality of care oversight, but regulations have not yet been developed (NASHP, 1996). Other states, such as South Carolina and Tennessee, have not yet implemented these special protections. Some states have begun to examine the feasibility of implementing these special consumer protections. The experiences of some of these states are detailed below.

California

A pilot ombudsman program serving all managed care consumers in the Sacramento area will be financed by three private health foundations, the Henry J. Kaiser Family Foundation, Sierra Health Foundation and California Wellness Foundation, and administered by the Center for Health Care Rights (CHCR). Funding for this 4-year project is $4 million, with an initial 2-year award of $1.6 million. The program will address managed care questions and handle specific complaints with plans, and is scheduled to begin in March 1997 (JCHC, 1996)

Colorado

This state recently enacted a new insurance regulation involving consumer appeals of claim denials. The new rule applies to all health plans that employ utilization review in their claim determinations. Health plans affected by the rule are required to 1) develop written standards for making UR decisions and communicating decisions to covered persons and their providers, 2) make the UR decision within two days of receipt of all information relevant to the decision, 3) notify the insured and provider by telephone of adverse decision within one day, 4) notify the provider by telephone within one day of decision after an admission, 5) make determinations on retrospective review within 30 days, and notify provider and insured of adverse decision within 5 days, 6) provide in writing the reason for an adverse determination and instructions for appeal, and 7) reconsider adverse determinations within one day of request. Appeals are to be considered by a peer of the treating provider. A covered person may request a second level grievance review of a still unresolved grievance, for which the carrier must appoint a grievance review panel. The rule also addresses expedited appeals.

Connecticut

In this state, PA 97-99 generated from House Bill 6883 allows an enrollee or his provider acting for him, once he has exhausted all internal appeals procedures of a managed care organization (MCO) or Utilization Review (UR) Company, to appeal to the Health Commissioner. The Health Commissioner contracts with an independent source which is either an independent UR Company, a Peer Review Organization (PRO), or nationally recognized health experts or institutions. In the state of Connecticut, the decision by the external review agent is binding.

According to the Senior Attorney of the Office of Legislative Research, the evidence of a need for an external review was mainly anecdotal. There was a basic skepticism that HMOs were not objective in their decisions, and there was a general belief that consumers weren't aware of the grievance procedures. (This belief was not concluded from a consumer survey). The state did conduct a survey of HMOs' clinical procedures and from this survey realized that the state of Connecticut had an overabundance of drive-thru deliveries and 24 hour mastectomies. It was this type of evidence that they used to determine a need for an external appeals process.

Florida

Since 1985, Florida has administered a Statewide Provider and Subscriber Assistance Program (SPSAP), which hears enrollee grievances against HMOs that have not been resolved to the enrollee s satisfaction (Agency for Health Care Administration, 1996). Responsibility for hearing provider grievances, such as those involving quality or continuity of care, was added in 1993. Enrollees who have exhausted the managed care entity s internal appeal process must be told by their plans that they may make a written appeal to the Agency for Health Care Administration, which reviews the case to determine if it will be selected for hearing by a six-member panel, composed of representatives from the Agency and the Department. The panel hears the case and makes a recommendation to the Agency or Department, depending on which has regulatory authority for the case. The Agency or Department issues a final determination, which, although not binding on the plan, may lead to imposition of fines if the plan does not comply. The program also reviews quarterly unresolved grievance reports submitted by managed care entities. Initially, responsibility for the program fell to the Department, but was transferred to the Agency in 1993. The volume of cases rose from 26 in 1991, to 140 in 1995. Day to day operations of the program are handled by two FTEs housed in the Agency. The panel members serve as needed, and the requirements of the panel are included in their job descriptions.

The Agency also operates an HMO hotline, which receives approximately 2,000 calls per month. In addition, a Volunteer Statewide Managed Care Ombudsman Committee within the Agency for Health Care Administration is currently being developed, and will serve in a consumer education, protection and advocacy role. Legislation is only now being explored, so the functions of the ombudsman and a determination of staffing and funding requirements are not yet available. Indications are that the ombudsman will assist consumers who have not yet exhausted the internal appeals process, and will provide a link between the hotline and the SPSAP (Personal communication, 1996).

Maryland

Since 1986, a Health Education and Advocacy Unit has operated within the Office of the Attorney General. Two FTEs plus a trained volunteer staff (retired health care and insurance professionals, student interns from medical and law schools) mediate consumer complaints and educate consumers. The annual volume of 4,000-6,000 calls on their toll-free hotline results in approximately 1,000 complaints, involving Medicare, Medicaid, indemnity-insurance, managed care plans and third party administrators. The unit initially received only billing questions, but in recent years has received a growing number of complaints regarding medical necessity and quality of care. While the unit does not directly handle complaints against physicians and health professionals regarding quality of care or diagnostic accuracy, they will accept such complaints and forward them to appropriate regulatory boards for review. The unit also has the regulatory authority to monitor the progress of complaints referred to regulatory boards or the Insurance Commissioner (Maryland Consumer Courier, 1990). As part of the AG s Consumer Protection

Division, the unit has regulatory authority over violations of consumer protection laws, but has no adjudicatory authority. The unit will take calls from providers, but only on behalf of patients. Complaints are tracked by industry and type of complaint. Approximately, 80-90% are resolved in 4-6 months. The success rate is 75-85%, and is based on the consumer s initial request. The annual budget of approximately $100,000 is funded through the Office of the Attorney General (Personal communication, 1996).

New Jersey

Chapter 26 of the New Jersey Administrative Code outlines that state's external review process. Any HMO member, and any provider acting on behalf of an HMO member with the member's consent, who is dissatisfied with the results of an HMO's internal appeal process, has the right to pursue his or her appeal to an Independent Utilization Review Organization (IURO). An appeal to the IURO must be made within 30 business days of receiving a final Stage 2 decision from the HMO. An IURO designated by the New Jersey Department of Health and Senior Services will determine whether the member was deprived of a medically necessary covered service, as a result of the HMO's utilization management determination. The Department will assign appeal requests to an approved IURO. The IURO has 30 business days to complete the preliminary and full review of the appeal. If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend in writing to the member and/or provider, the HMO and the Department, the appropriate covered health services the member should receive. The HMO then decides whether it will accept and implement or reject the recommendation offered by the IURO.

According to the Chief of the Office of Managed Care in the New Jersey Department of Health, this legislation came about as a reaction to a general perception that HMOs were inappropriately denying care to certain groups of enrollees. He added that there was confirmation of this from many interest groups, especially the New Jersey Medical Society and the hospital industry. Some data on HMO denial was brought to their office's attention. The Chief stressed his opinion that the decision to establish external review was not an arbitrary reaction but rather a response to the perceived ineffectiveness of the HMOs' internal review processes.

Rhode Island

According to the Rhode Island Administrative Code, in cases where the second level of appeal to reverse an adverse determination is unsuccessful, the review agent shall provide for an external appeal by an unrelated and objective appeal agency, selected by the Director of the Department of Health. The external appeal review and decision is based on the medical necessity for the care, treatment, or service, and the appropriateness of service delivery for which authorization has been denied. The decision of the external appeal agency is binding on the health plan; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to a judicial review in a court of law.

External Review of Appeals legislation has been in existence in Rhode Island for 3 years; it was the first of such legislation in the country. As explained by the Managed Care Officer for the Rhode Island Department of Health, it was originally proposed by a legislator who had a son who committed suicide because he was denied care by his HMO. This legislator pushed the proposal through the General Assembly, convincing the state government of the need for this legislation because of the existence of a trend for HMOs to deny care. When contemplating the passage of the bill, the General Assembly heard supporting testimony from consumers and the mental health community.

Medicaid Managed Care Ombudsman Programs

The Center for Health Care Rights was to publish a report in December 1996 summarizing the experience of 14 Medicaid managed care ombudsman programs (Center for Health Care Rights, 1996). It is not yet available, but will contain information on issues that may be considered in developing an ombudsman program, as well as data on the experiences of 14 Medicaid managed care ombudsman programs throughout the country**.** Not included in the report is Maryland, which is scheduled to begin a Medicaid managed care ombudsman program in March 1997. Virginia s Department of Medical Assistance Services (DMAS) does not operate an ombudsman program for Medicaid managed care enrollees (although it operates a recipient assistance line), but instead operates a formal appeals process.

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State Comparisons of Independent External Appeals Process

Methodological note: Information in this analysis is based on a review of current law and/or regulation. Most are recent (RI's law has existed for three years; CT's law is in the rule-making process; VA passed its law in 1995). Phone interviews with selected states were conducted to verify interpretations. The UR processes reviewed involve the standard process, not expedited review.)

Characteristics	VA	NJ	CT	RI
Type of decision being appealed	UR adverse decision	UR adverse decision	UR adverse decision	UR adverse decision
External				
When does an appeal become external?	*(As part of but not after the appeal of the reconsideration of adverse decision -- 2nd level)*	*After* the final stage 2 decision	*After* exhausting all internal appeal procedures	*After* the 2nd level of appeal (final level)
Relation of the reviewer to the plan		Independent UR organizations	"independent & impartial"	"unrelated objective agency"
Independent				
Qualifications of the reviewer	Peer of the treating health care provider specialized in a discipline pertinent to the issue under review	Qualifications not stated; but Health Commissioner may establish qualifications	Nationally recognized health experts	Licensure the same as the ordering practitioner or a licensed physician or dentist as appropriate
Relation of the reviewer to the plan	Not be employed by or a director of the utilization review entity	Independent UR organizations	"independent & impartial"	"unrelated objective agency"
Reimbursement arrangement	Plan pays the reviewer directly	Health Commissioner establishes fees for external review; plan pays the Health Department	Enrollee pays a $25 fee process claim (*In CT, the Insurance Department is funded through fees from the insurance companies*; *presumably insurers cover the balance)*	50% paid by patient or provider of record & 50% paid by organization that denied coverage
Selection of the reviewer (individual or organization)	Plan appears to designate the individual to review BOI/ Commissioner of Insurance has no role; Department of Health/ Health Commissioner has no role	Department of Health & Senior Services/ Director designates the reviewing entity	Insurance Commissioner, after consultation with the Public Health Commissioner designates the reviewing entity	Department of Health/Director designates the reviewing entity
Reviewer's involvement in previous decisions or reconsideration by the plan	No previous involvement	No previous involvement	Presumably no previous involvement	No previous involvement

Authority of the reviewer	Uncertain (no explicit statement in Code) as to whether the decision made by the reviewer is binding on the plan	Recommends to the HMO for its consideration appropriate treatment	Binding on the HMO law does not address whether the dissatisfied party has recourse through the courts.	Binding on the HMO; unsatisfied enrollee has recourse through the courts

Outline of the process in Virginia as defined at section 38.2-5406ff
(Standard process not expedited)

- Request for treatment
- Adverse decision
- Reconsideration of adverse decision (first level)
- Final adverse defemination
- ***Appeal of final adverse determination (2nd level)***

APPENDIX L: A SURVEY OF VARIOUS STATES' REGULATION OF MANAGED CARE ORGANIZATIONS' QUALITY ASSURANCE

Introduction

The states chosen for this survey were selected based upon a recommendation made by staff of the National Committee for Quality Assurance (NCQA). The majority of the states in the survey regulate quality assurance functions of managed care organizations (MCO) through their states' health departments as part of a bifurcated regulatory system that also includes the states' departments of insurance.

State managed care regulatory administrators in the following states were interviewed: Florida, Nevada, Oklahoma, Pennsylvania, Rhode Island, SouthCarolina, Vermont and Minnesota. In addition, contact was also made with the chairperson of the National Association of Managed Care Regulators' committee studying the feasibility of national model managed care regulations and personnel from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). JCAHO has recently adopted quality assurance standards for accrediting managed care organizations and is attempting to qualify as an MCO external quality assurance review organization in those states that require managed care organizations to undergo external reviews.

Among the states that were surveyed, the primary difference between the states' regulation of MCOs' quality assurance is in regard to the extent that a state itself takes an active role in the evaluation of managed care organizations' quality assurance programs as compared to relying primarily on the findings of an independent external review organization.

States' expectations for MCOs' quality assurance programs are basically the same among the surveyed states as evidenced by the states' requirements for:

Data collection and analysis of access, accessibility, continuity and coordination of health care services.

Defined service areas

Monitoring of health care outcomes

Processes for:

- **Internal quality improvement assessment**
- **Peer review**
- **Complaint resolution**
- **Appeals**
- **Medical audits**
- **Remedial action to correct identified deficiencies**

Procedures for:

- **Corporate accountability**
- **Reporting of quality assurance activities to state public health personnel**

PENNSYLVANIA

PLAN REVIEW

Prior to the time that the Pennsylvania Department of Insurance initially issues a Certificate of Authority to a MCO, the Department of Health's Bureau of Quality Assurance has reviewed the MCO's quality assurance procedures that are part of the organization's application for a Certificate. The organization's quality assurance procedures are reviewed for compliance with the Department of Health's statutory and regulatory quality assurance standards for managed care organizations, which Pennsylvania Health Department personnel attest go beyond NCQA's standards.

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL REVIEWS

Pennsylvania's Health Maintenance Organization (HMO) regulations require that, within one year of the receipt of a Certificate of Authority, and every three years thereafter, or when the Department of Health shall direct for cause, each HMO shall have an external quality assurance assessment performed. The Department of Health also conducts a state onsite quality assurance review, sometimes in coordination with the external review organization. The Department then gathers all of the quality assurance assessment information and issues a report to the MCO and to the Department of Insurance as to whether or not the Commonwealth's standards for MCO quality assurance have been met by the organization.

External quality assurance reviews may only be performed by organizations that are approved by the Department of Health, based upon the organization's recognized experience in the appraisal of medical practice and quality assurance in a MCO setting.

Pennsylvania sends out an **Invitation to Qualify as a Quality Review Organization (QRO)** to interested applicants. The Commonwealth has approved three external QROs with approval of a fourth organization pending. The three that have been approved are the Accreditation Association for Ambulatory Health Care, Inc., the National Committee on Quality Assurance (NCQA) and Health Pro, Inc. of Massachusetts. The approval of the Joint Commission on the Accreditation of Health Care Organizations is pending.

Before the Department approves a QRO, the organization must perform one free demonstration external assessment of a MCO designated by the Department. Organizations whose performance is unsatisfactory during the demonstration assessment are not granted approval. The Department also requires that the QRO include a list of terms and conditions placed upon the review organizations by the Department in their contracts with the MCO, including the Department's right to participate in each external review. Approval status of a QRO can be removed at any time if an organization fails to meet the Department of Health's standards. On an annual basis, representatives from each approved QRO must travel to the Pennsylvania Department of Health for a meeting to evaluate the effectiveness of the external quality review approach.

Pennsylvania MCOs are responsible for selecting from among the state-approved QROs one to review their organization and are responsible for paying for and scheduling the reviews. The Department is not a party to the contracts between the MCO and the QRO and it assumes no financial responsibility for any aspect of the review. Neither does the Department guarantee the performance of any of the approved Quality Review Organizations. The QRO reports are submitted to both the MCO and to the Health Department and are not public documents. They are used only by the Department for evaluating the MCO's quality assurance program.

STATE ONSITE REVIEWS

Department of Health, Bureau of Quality Assurance personnel (approximately thirteen staff members), conduct the administrative desk review of the MCOs' quality assurance programs as well as conduct onsite quality assurance reviews. In some instances, the Commonwealth's surveyors accompany the QRO surveyors. The Bureau issues a report that is combined with the external review organization's findings. It also conducts complaint investigations. According to Pennsylvania state authorities who work with MCOs, most MCOs work fairly cooperatively with the Commonwealth to correct quality assurance problems in the interest of avoiding negative publicity. Funds to support the Commonwealth's Department of Health MCO quality assurance oversight come primarily out of the fees assessed by the Commonwealth for initial Certificates of Authority and renewal certificates. Currently, Pennsylvania has 25 certified HMOs with three million people enrolled in the HMOs.

VERMONT

In Vermont, the regulation of managed care organizations originated in the

Department of Banking and Insurance. The Vermont legislature later determined that this department was not the appropriate agency to deal with health care quality assurance issues and created the Vermont Health Care Authority (VHCA). An executive branch agency, VHCA, is responsible for strategic planning for health care reform and health care issues, as well as all health care policies and regulations.

PLAN REVIEW

The Vermont Health Care Authority is responsible for reviewing the quality assurance procedures of each applicant MCO and existing MCOs. MCOs that apply for a Certificate of Authority must first have the approval of the VHCA that their quality assurance procedures agree with Vermont's MCO quality assurance regulations and statutes before they are issued a Certificate of Authority. Vermont's statutes and regulations governing quality assurance are less comprehensive than Pennsylvania's and, according to VHCA personnel, are subject soon to revision.

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL REVIEWS

Vermont's process for approving external MCO quality assurance review organizations mirrors that of Pennsylvania's through the solicitation of bids from accreditation agencies such as NCQA. Vermont law requires a MCO to be subject to a quality assurance evaluation every three years or more often if necessary. VHCA has the authority to designate who may conduct the quality assurance review, and as of now, has only allowed approved MCO accreditation agencies to conduct the reviews. The approved accreditation agencies for Pennsylvania have also been approved by Vermont. Cost is a factor in regard to what accreditation organization a MCO might choose, with the larger MCOs opting for NCQA while the smaller organizations tending to choose"Triple A", i.e., the Accreditation Association for Ambulatory Health Care, Inc.

STATE ON-SITE REVIEWS

A state onsite review of quality assurance is required by Vermont law, however, the Vermont Health Care Authority does not conduct the state's review but contracts with a New York-based audit group, "Island Pro." Island Pro conducts reviews in New York for the Medicaid program, and according to VHCA personnel, has the needed expertise to conduct the external reviews of MCOs' quality assurance programs in a way that is more cost effective for Vermont. VHCA's personnel review the external and state quality assurance reports and make a recommendation to the Department of Banking and Insurance regarding the MCO's compliance with state law governing MCO quality assurance prior to the time a Certificate of Authority is issued. VHCA has four staff personnel dedicated to quality assurance compliance. There are six certified HMOs in Vermont. Subscriber complaint review is conducted by VHCA and, according to VHCA

personnel, the HMOs in Vermont have been willing to correct their quality assurance problems when identified by the VHCA. Funding for the quality assurance functions of VHCA comes primarily from MCO applications and certificate fees.

FLORIDA

PLAN REVIEW

Managed care organization regulation in Florida is shared between the Florida Department of Health Care Administration and the Florida Department of Insurance. The Department of Health Care Administration administers the MCO quality assurance reviews by dividing the reviews into two administrative sections: Medicaid contractual plans and commercial HMO plans. Florida's quality assurance regulation for MCOs is unique among most of the states surveyed in that, within a two year time frame after initially receiving a Certificate of Operation from the Department of Insurance, a MCO must actually receive accreditation by an external review organization or risk loosing its Certificate. This differs from most of the other states surveyed that incorporate an external review organization assessment in that the other states limit their regulations to requiring that the MCO undergo a review by an external review organization but they do not require actual accreditation by the review organization.

COMMERCIAL PLANS

The commercial plans are also required to be preapproved by the Department for compliance with Florida's statutes and regulations governing managed care quality assurance and must pass an initial survey conducted by the Department personnel before they are issued a Health Care Provider Certificate. A copy of the Certificate is sent to the Department of Insurance that issues the Certificate of Operation. Florida's commercial MCOs must be accredited by an external accreditation organization within two years of being issued a Certificate of Operation. If a MCO fails to be accredited within the given time frame, the state conducts a compliance survey that is similar to the initial state survey to review areas requiring quality improvement. A survey is also conducted by the state when a MCO wants to expand its service area.

Department field staff who are nurse consultants also conduct complaint investigations in regard to quality of care issues. Non-compliant MCOs are sent a statement of deficiencies and must file a plan of correction within ten days of receipt of the deficiency statement. Sanctions for the revocation of the Health Care Provider Certificate are provided for in Florida law. The fees a MCO files with its initial application for certification ($1,000) and the renewal fees ($1,000) go towards supporting the Department of Health's quality assurance compliance activities, as well as a yearly assessment that a MCO must pay to a state trust fund. The MCOs are responsible for all costs associated with accreditation.

MINNESOTA

PLAN REVIEW

Minnesota regulates managed care organizations entirely through the Minnesota Department of Public Health. The license to operate a MCO is issued through the Department of Public Health. Minnesota's statutes and regulations that govern MCO quality assurance emphasize the importance of MCOs having their own system of quality assurance evaluation with the state's role identified as assuring that the systems are effective through periodic examinations of the systems. The entire MCO application review is conducted by the Department of Public Health, rather than the Department conducting only the quality review aspect of the application as is done in most of the states surveyed. Audit staff conducts the review of the financial portions of the applicant's plan which is combined with staff review by health facility personnel of each plan's quality assurance process. Minnesota has approval for 21 full time employees to conduct MCO desk and onsite reviews.

ONSITE QUALITY ASSURANCE REVIEWS

STATE ONSITE REVIEWS

While Minnesota requires that each MCO's quality assurance process be examined no less than every three years, these periodic examinations are conducted only by Minnesota Department of Health staff. Minnesota does not require an external quality review process by state-approved review organizations such as NCQA.

Minnesota's Department of Public Health has the authority to apply sanctions for the failure of MCOs to comply with MCO quality assurance statutes and regulations. The most serious sanction allowed is the revocation of the MCO's license. Although not a common occurrence, Minnesota has required some HMOS in the state to pay sizable penalties for noncompliance with state quality assurance laws. The financing of Minnesota's regulatory MCO program comes primarily from licensure application fees ($16,000 base and $.46 per member) with separate fees ranging from $2,000-$3,000 for the periodic examinations. Minnesota currently licenses 16 managed care organizations.

OKLAHOMA

PLAN REVIEW

The Oklahoma Department of Health issues the license to operate a MCO with the Department of Insurance having review and comment authority. Oklahoma reviews MCO plans to assure that the quality assurance plans and utilization programs meet state statutes and regulations. Oklahoma's quality assurance standards are similar to federal HMO qualification rules under 42 CFR, Part 400429, Section 417. 106.

The Oklahoma Department of Health MCO section has a Licensure and Quality Assurance unit with four staff members who review and preapprove the quality assurance sections of the plans and examine the reports from the external review organizations prior to the time that a recommendation is made for licensure.

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL REVIEWS

Oklahoma regulations provide that HMOs are required to have an external review at least once every three years and more often if necessary. The Commissioner of Health can direct the Health Department to conduct the review or an organization approved by the Health Department can be responsible for the review. The Oklahoma Health Department has approved NCQA, Health PRO, Inc., JCAHO, and the Accreditation Association for Ambulatory Care, Inc. The MCOs' nominate the review organization they wish to have review them, but final selection is at the discretion of the Health Commissioner. Complaints are dealt with by Department staff.
Oklahoma currently licenses nine HMOs with a total of 266,000 members.

RHODE ISLAND

PLAN REVIEW

The regulation of managed care organizations in Rhode Island is divided between the Rhode Island Department of Health and the Rhode Island Department of Business Regulation. As in a number of the other states surveyed, the Department of Health is charged with reviewing MCOs' quality assurance programs to determine if the programs meet the state's laws governing quality assurance for MCOs. Currently, the Director of Health issues a certificate for satisfactory compliance with the regulations which allows the Department of Business Regulation to issue a license to operate the MCO. Any modifications to the MCO plans after licensure have to be sent to the Department of Health for review and approval of "material modifications" i.e., "any change to the information initially filed with the Department of Health including, but not limited to, systematic changes in provider networks and mechanisms for the management and control of the use of covered services by enrollees."

ONSITE QUALITY ASSURANCE REVIEWS

EXTERNAL ONSITE REVIEWS

For MCOs that achieve licensure, Rhode Island, like Florida, requires that the MCOs be accredited by an external review organization acceptable to the Director of Health, within two years of initial licensure, or as deemed appropriate by the Department for those currently licensed as of January 1, 1994. Rhode Island does not include in its regulations a description of its process for approving accreditation organizations beyond the fact that the Director of Health has the authority to approve the accreditation organization. In practice, nationally-recognized MCO quality assurance accreditation organizations, such as NCQA, are routinely considered acceptable. All costs for accreditation are paid for by the MCO.

STATE ONSITE REVIEWS

Rhode Islands' regulations require that the Director of Health conduct examinations concerning the quality of health care services of any MCO that is licensed, not less than once every year, to determine continued compliance with the statutory and regulatory standards governing quality of care. Deficiencies found within the review are filed with the MCO by the Department and the MCO must present a plan of correction that is acceptable to the Director of Health. The expenses of the review are assessed against the MCO being examined and remitted to the Director of Health. The Director of Health has the right to hold hearings regarding MCOs that are in violation of the quality assurance standards. The recommendation and finding of the Director of Health with respect to matters relating to the quality of health care services provided by a MCO in connection with any decision regarding denial, suspension, or revocation of a license is conclusive and binding upon the Director of Business Regulation.

Rhode Island has three professional staff members who review the MCO applications and conduct the onsite state reviews. There are six licensed MCOs in Rhode Island with approximately 250,000 subscribers.

Funding for the MCO quality assurance reviews comes from application fees that are $3,000 per application. Rhode Island also has a process by which it bills MCOs for any time that is spent by employees on the review and approval process by using a software package "Timesheet."

NEVADA

PLAN REVIEW

Nevada regulates managed care organizations' qualify assurance programs through the Department of Human Resources' Health Division. The Department of Insurance issues the Certificate of Authority. Nevada's regulations and statutes which govern quality assurance of MCOs require that the Health Division examine each MCO application according to criteria stated in the regulations prior to granting a Certificate of Authority. Each applicant has to demonstrate that it has a quality assurance program that meets the state's criteria, that it has a method for evaluating the effectiveness of the quality assurance program and the services that are provided to members and that it includes a data collection program.

EXTERNAL ONSITE REVIEWS

MCOs in Nevada must submit to an external review organization examination of the quality of the health care services provided by a MCO. The criteria for approving an external review organization are that an organization must be: (a) the Federal Government for federal qualification as an HMO; (b) a group which is nationally recognized to provide accreditation of HMOs; or (c) a person approved by the state board of health. The board of health maintains a list of at least two persons whom the board has approved to assist the board in conducting the examination of an organization. Once the examination is completed, the results of the Health Division go both to the MCO and to the state board of health. The state board of health reports to the Commissioner of Insurance if the organization meets the quality assurance standards prior to the issuance of a Certificate of Authority. Each year, the MCO must also file an annual report to the Nevada Health Division which addresses its compliance with the state's MCO quality assurance regulations and statutes. Nevada's Health Division consists of one staff member assigned to MCO quality assurance review. Funding for the review process comes from state general funds. There are 12 licensed HMOs in Nevada with 278,201 subscribers.

SOUTH CAROLINA

PLAN REVIEW AND EXTERNAL ONSITE REVIEWS

South Carolina regulates managed care organizations exclusively through the South Carolina Department of Insurance. South Carolina's regulations governing quality assurance procedures for MCOs require that, following the review of the MCO application, each MCO must have a "Quality Assurance Review" by December 31, 1996, and at least every three years thereafter. The "Quality Assurance Review" must be performed by a qualified organization performing audits based upon similar criteria as set forth in the National Committee for Quality Assurance (NCQA) guidelines. Each HMO selects the external review organization and the cost of the review is paid by the MCO. The Director of Insurance includes this review in his examination of every MCO.

All the expenses of the examination for a recommendation for a Certificate of Authority under the regulations are assessed against the organization being examined and remitted to the Commissioner of Insurance. South Carolina has not adopted additional guidelines, other than what is in the law, for choosing external review organizations. Currently, South Carolina has 14 licensed MCOs and administers the regulatory program through a six person staff.

Conclusion

The states' regulations governing managed care organizations' quality assurance programs were also compared with the Commonwealth of Virginia's **Rules Governing Health Maintenance Organizations**, (State Corporation Commission, September 1, 1987). Virginia's regulations incorporate a section entitled "Grievance Procedure" and require a description of "procedures and programs established by health maintenance organizations to (1) assure both availability and accessibility of adequate personnel and facilities and (2) assess the quality of health services provided." The current HMO regulations and statutes in Virginia are heavily weighted toward regulating the financial obligations of an HMO, with only the reference made above to the quality of the health care services provided by the HMO or to systems that should be in place to monitor and evaluate the quality of health care services. It should be of benefit for the Virginia Department of Health to further explore its potential role in regard to quality assurance oversight of managed care organizations.